

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-036403

5093

STATE FILE NUMBER

Registration District No. 149 Primary Registration District No. 1002 Registrar's No.

DO NOT WRITE
ON THIS STUB

AMENDED

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Rev. 4/59

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USE BLACK INK
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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OF

FULL DATE OF DEATH 1963

1. PLACE OF DEATH a. COUNTY JACKSON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI COUNTY JACKSON	
b. CITY (If outside corporate limits, give TOWNSHIP only) KANSAS CITY		c. CITY OR TOWN KANSAS CITY	
Length of stay in 1b 13 yrs		Inside Limits Yes No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) V A HOSPITAL		d. STREET ADDRESS (If outside, give location) 6818 EAST 12TH TERRACE	
3. NAME OF DECEASED (Type or print) First CLARENCE Middle PAYNE Last REYNOLDS		4. DATE OF DEATH Month September Day 16 Year 1963	
5. SEX Male	6. COLOR OR RACE White	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 6-2-94
9. AGE (last birthday) 69		10. IF UNDER 1 YEAR Months 6 Days 2 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired salesman		10b. KIND OF BUSINESS OR INDUSTRY Savannah, Missouri	
11. BIRTHPLACE (City and state or country) U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13a. FATHER'S NAME Con J. Reynolds		13b. MOTHER'S MAIDEN NAME Ella Payne	
14. NAME OF HUSBAND OR WIFE Nell F. Reynolds		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WWI	
16. SOCIAL SECURITY NO. VA Hospital Official Records, K.C. Mo.		17. INFORMANT Nell F. Reynolds	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia with bronchial plug aspiration DUE TO (b) Superimposed bacterial infection upon DUE TO (c) Pulmonary tuberculosis Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 12:20p Month, Day, Year 6-17-63		20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) VA Hospital		20f. CITY, TOWN, OR LOCATION Kansas City, Mo.	
21. I attended the deceased from 6-17-63 to 9-16-63 Death occurred on 9-16-63 at 12:20p on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE ROBERT M. BROWN, M.D.	
22b. ADDRESS VA Hospital, Kansas City, Mo.		22c. DATE SIGNED 9-16-63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE 9-19-1963	23c. NAME OF CEMETERY OR CREMATORY VA Cemetery	23d. LOCATION (City, town, or county) Wadsworth, Kansas
24. FUNERAL DIRECTOR Muehlebach		25. DATE RECD. BY LOCAL REG. 9-17-63	
26. REGISTRAR'S SIGNATURE Bessie Smith			

NAME OF DECEASED

RESIDENCE

DECEASED'S CITY

DECEASED'S CITY

DATE OF DEATH

DATE OF DEATH

DATE OF DEATH

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed

Robert H. Linder

Licensed Embalmer No.

5103

P. O. Address

K. G. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.